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PROPOSALS AND ISSUES RELATING TO THE TAX-EXEMPT STATUS OF NOT-FOR-PROFIT HOSPITALS INCLUDING DESCRIPTIONS OF H.R. 1374 and H.R. 790

Scheduled for a Hearing
before the
COMMITTEE ON WAYS AND MEANS
on July 10, 1991

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION

July 9, 1991

JCX-10-91

J862-21
H782-29

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INTRODUCTION

The House Committee on Ways and Means has scheduled a public hearing on July 10, 1991, to review the tax-exempt status of not-for-profit hospitals. The hearing will focus on the tax and health issues relating to not-for-profit hospitals and their operations. The Committee also will receive testimony on H.R. 1374, introduced by Mr. Donnelly, and H.R. 790, introduced by Mr. Roybal.

This document,[1] prepared by the staff of the Joint Committee of Taxation, provides a brief description of present law (Part I), descriptions of H.R. 1374 and H.R. 790 (Part II), and the principal economic issues raised by the tax treatment of not-for-profit hospitals (Part III).

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[1] This document may be cited as follows: Joint Committee on Taxation, Proposals and Issues Relating to the Tax-Exempt Status of Not-for-Profit Hospitals Including Descriptions of H.R. 1374 and H.R. 790 (JCX-10-91), July 9, 1991.

I. OVERVIEW OF TAX RULES APPLICABLE TO NOT-FOR-PROFIT HOSPITALS

A. Requirements for Tax-Exempt Status

1. Charitable purpose

Code section 501(c)(3) lists certain types of organizations that are exempt from taxation, including those "organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes . . . no part of the net earnings of which inures to the benefit of any private shareholder or individual . . . ." Although the furnishing of medical care and the operation of a not-for-profit hospital are not specifically mentioned, they have long been considered to be activities in furtherance of charitable purposes described in section 501(c)(3) so long as certain conditions are met.[2]

In 1956, the Internal Revenue Service (IRS) first issued a formal ruling listing the conditions that must be met for a not-for-profit hospital to be recognized as a tax-exempt charitable organization under section 501(c)(3) (Rev. Rul. 56-185, 1956-1 C.B. 202). The IRS ruled that a hospital would be exempt if it met the following four conditions. First, the hospital must be organized as a not-for-profit organization for the purpose of operating a hospital for the care of the sick. Second, it must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those able and expected to pay. Third, the hospital must not restrict use of its facilities to a particular group of physicians. Finally, its earnings must not inure, directly or indirectly, to the benefit of any private shareholder or individual (this last requirement merely clarified a restriction applicable to all organizations under section 501(c)(3) (described in item A.2., below)).

This ruling was most important for its second requirement, the "financial ability" requirement. The IRS explained that requirement by stating:

> The fact that its charity record is relatively low

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[2] Although not-for-profit hospitals generally are recognized as tax-exempt by virtue of being "charitable" organizations, some also could qualify for exemption as "educational organizations" because they are organized and operated primarily for medical education and research purposes. This discussion, however, focuses on the most commonly recognized standard under section 501(c)(3), a charitable purpose.

> is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may furnish services at reduced rates which are below cost, and thereby render charity in that manner. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered.

Three years after publication of Revenue Ruling 56-185, the Treasury income tax regulations interpreting section 501(c)(3) were significantly revised. The amended regulations provided that:

> The term "charitable" is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of "charity" as developed by judicial decisions.[3]

The IRS relied upon the amended regulations to revise the hospital exemption standards in Revenue Ruling 69-545, 1969-2 C.B. 117. In that ruling, the IRS expressly removed the financial ability requirement in Revenue Ruling 56-185 and added a new test, known as the "community benefit standard." In the new ruling, the IRS explained that the promotion of health is "one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community."

The community benefit standard, which remains the standard applied by the IRS today, focuses on a number of factors indicating that the operation of a hospital benefits the community. In Rev. Rul. 69-545, the IRS determined that the standard was satisfied by a hospital that operated an emergency room open to all persons and provided hospital care in non-emergency situations for everyone able to pay the cost thereof, either themselves, or through third-party reimbursement. The hospital also had a board of directors drawn from the community, an open medical staff policy, treated persons paying their bills with the aid of public

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[3] Treas. Reg. section 1.501(c)(3)-1(d)(2).

programs (like Medicare and Medicaid), and applied any surplus to improving facilities, equipment, patient care, and medical training, education and research.

The validity of the new standard in Revenue Ruling 69-545 was challenged in a class action by various health and welfare organizations and several private citizens. In Eastern Kentucky Welfare Rights Organization v. Simon, 370 F.Supp. 325, 338 (D.D.C. 1973), a Federal District Court sustained the challenge, and concluded that Congress intended to restrict the term charitable to its narrow sense of relief of the poor. The Court of Appeals reversed the District Court, however, and upheld the broader interpretation of charitable taken in Revenue Ruling 69-545. Eastern Ky. Welfare Rights Org. v. Simon, 506 F.2d 1278 (D.C. Cir. 1974), vacated on other grounds, 426 U.S. 26 (1976). The Court of Appeals explained that the term "charitable" is "capable of a definition far broader than merely the relief of the poor." The Court also noted that the "financial ability" requirement of Rev. Rul. 56-185 was not overruled but was simply supplemented by an alternative method whereby a not-for-profit hospital could qualify as a tax-exempt charitable organization.

In 1983, the IRS applied the community benefit standard to a hospital identical to the one exempted in Rev. Rul. 69-545 but for the fact that it did not operate an emergency room (Rev. Rul. 83-157, 1983-2 C.B. 94). In the 1983 ruling, the IRS determined that the other factors present in Rev. Rul. 69-545 indicated that the hospital promoted the health of a class of persons broad enough to benefit the community. The IRS also explained that an emergency room was not necessary where a State health planning agency had made an independent determination that the operation of an emergency room would be unnecessary and duplicative.

2. Prohibition of private inurement

In general

A not-for-profit hospital (and any other organization) is not eligible for an exemption under section 501(c)(3) if any part of its net earnings inures to the benefit of a private individual. This prohibition is intended to ensure that the organization fulfills the rationale for tax exemption by devoting itself exclusively to the public good, and to prevent the organization from conferring financial benefits (other than reasonable compensation) on persons having a personal or private interest in its activities.

Forms of inurement

Private inurement can take a variety of forms, including the payment of dividends or excessive compensation to an

individual with an interest in the organization. In determining whether an employee or other recipient of payments from an exempt organization has received excessive compensation, all benefits received in exchange for services--such as bonuses, deferred compensation, below-market interest or unsecured loans, payments of personal expenses, the personal use of cars or residences, and other benefits--are taken into account, as well as salaries. See, e.g., Harding Hosp., Inc. v. United States, 505 F.2d 1068 (6th Cir. 1974) (provision of office space, equipment and services by hospital to physicians at below-market rate); Kenner v. Commissioner, 318 F.2d 632 (7th Cir. 1963) (funds of hospital used for personal expenses); Lowry Hosp. Ass'n v. Commissioner, 66 T.C. 850 (1976) (unsecured, below-market loans made by hospital); Maynard Hosp., Inc. v. Commissioner, 52 T.C. 1006 (1969) (diversion of pharmacy income); Sonora Community Hosp. v. Commissioner, 46 T.C. 519 (1966) (income from X-ray department and laboratory diverted to physicians).

Application of the reasonable compensation test generally is not dependent upon whether the paying entity is tax-exempt or taxable. Reasonable compensation is the amount that would ordinarily be paid for like services by like organizations under like circumstances (see Treas. Reg. sec. 1.162-7(b)(3)). Under this standard, reasonableness generally is determined by reference to comparable employment agreements. Relevant factors may include the date on which the service contract was made, the size of the organization, the nature of the services provided, and the individual's qualifications, experience, and familiarity with the organization.

3. Information returns and penalties

Most tax-exempt organizations must file an annual information return[4] including the organization's gross income, expenses, disbursements for exempt purposes, balance sheet, total contributions, and the names, addresses, and compensation of an organization's officers, directors, trustees, and certain other highly-compensated employees (sec. 6033). This return is made on Form 990, Return of Organization Exempt From Income Tax. An organization (other than a private foundation, which is subject to other public inspection procedures) must make available for public inspection, a copy of its three most recent annual information returns at its principal office (sec. 6104(e)).

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[4] Churches (and certain related organizations) and certain organizations the gross receipts of which in each taxable year are normally not more than $5,000 are not required to file annual information returns (sec. 6033(a)(2)).

A hospital that fails to be operated exclusively for charitable purposes is subject to the loss of its Federal income tax exemption. A hospital also is subject to the loss of its exemption if any of its net earnings inure to the benefit of private individuals. There generally are no intermediate tax sanctions for improper activities engaged in by hospitals or other public charities.[5]

B. Business Activities of Not-for-Profit Hospitals and Their Related Entities

1. Application of unrelated business income tax (UBIT)

Income subject to UBIT.--Although generally exempt from tax on income from activities related to their exempt purpose, tax-exempt organizations are subject to the unrelated business income tax (UBIT) on their unrelated business taxable income. The term "unrelated business taxable income" means gross income derived by an organization from a trade or business which is regularly carried on and which is not substantially related to the performance of the organization's exempt purpose (aside from the organization's need or use of the business proceeds), less certain deductions directly connected with the trade or business. Unrelated business taxable income generally is subject to the Federal income tax at the applicable corporate or trust tax rates (sec. 511(a)).

Exceptions to UBIT.--Exceptions to the UBIT are provided for certain activities, such as where substantially all the business activities are performed by volunteers, substantially all of the merchandise sold was donated, and where the trade or business is carried on by an organization described in section 501(c)(3) (which includes non-profit hospitals and other "charities") primarily for the convenience of its members, students, patients, officers, or employees (sec. 513(a)). In addition, certain investment income (e.g., interest, dividends, royalties, and certain rents) generally is exempt from the UBIT, except where

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[5] The Code provides for penalty excise taxes which may be imposed upon private foundations and their managers for engaging in certain improper transactions, such as self-dealing transactions, failure to distribute income, excess business holdings, investments which jeopardize charitable purpose, and making certain "taxable expenditures" (secs. 4941-4945). Tax-exempt hospitals are not private foundations because they are specifically excluded from such tax classification (secs. 509(a)(1) and 170(b)(1)(A)(iii)). Thus, these penalty excise taxes generally are not applicable to hospitals and other public charities, i.e., those section 501(c)(3) organizations that are not private foundations.

derived from debt-financed property[6] or where derived from a controlled entity.[7]

A special rule also provides that, in the case of a hospital (or a college or university), all income derived from research performed for any person is excluded from the UBIT (sec. 512(b)(8)).

Deductions allowed for UBIT purposes.--For purposes of computing unrelated business taxable income, deductions are allowed for only those expenses that are directly connected with carrying on an unrelated trade or business. In this regard, the Internal Revenue Service recently stated that a hospital cannot simply rely on costs reported to the Health Care Financing Administration (HCFA) for Medicare purposes when computing its unrelated business taxable income.[8] The memorandum was based on a hypothetical case of a tax-exempt hospital that operated a retail pharmacy, the income from which was reported as gross income from an unrelated business. For UBIT purposes, the hospital attempted to deduct from the pharmacy income all costs allocated to the pharmacy on the Medicare cost reports filed with HCFA. The Service concluded, however, that since many costs allowed for Medicare purposes fail the "directly connected" test required for deductibility under UBIT, hospitals must demonstrate that the Medicare costs are allowable deductions under the Code, are directly connected to the unrelated business activities, and clearly reflect income in order to deduct those costs in calculating unrelated business taxable income.

2. **Controlled subsidiaries of not-for-profit hospitals**

Hospitals and other charities described in section 501(c)(3) must be organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, educational, or other similar purposes. Present

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[6] Income from debt-financed property generally is subject to the UBIT in the proportion in which the property is financed by debt (sec. 514(a)). Income derived from debt-financed property substantially all the use of which is substantially related to the organization's exempt purpose is not subject to the UBIT (sec. 514(b)(1)(A)).

[7] Interest, royalties, and rents (but not dividends) paid to a tax-exempt organization by an 80-percent owned entity are subject to the UBIT in proportion to the income of the controlled entity that would have been subject to the UBIT if derived directly by the controlling tax-exempt organization (sec. 512(b)(13)).

[8] See G.C.M. 39843 (April 18, 1991).

law is unclear governing the extent to which, in determining the primary purpose of a tax-exempt organization, the activities and income of controlled subsidiaries (tax-exempt or taxable) are to be taken into account. Consequently, tax-exempt organizations generally take the position that all activities carried on through controlled subsidiaries (or a chain of subsidiaries) are to be disregarded in determining if the parent organization satisfies the primary purpose test. The Internal Revenue Service generally has agreed with this position. Thus, hospitals and other tax-exempt entities can control a virtually unlimited number of subsidiaries (each subsidiary paying tax depending on whether it is a taxable or tax-exempt entity) without affecting the parent's tax-exempt status. Dividends paid by subsidiaries to a tax-exempt parent, however, may be a factor in determining whether the parent organization satisfies the primary purpose test under section 501(c)(3), which requires an organization to conduct exempt purpose activities commensurate in scope with its financial resources.[9]

C. Deductions for Charitable Contributions to Not-for-Profit Hospitals

1. Federal income tax

In general.--A deduction is allowed for Federal income tax purposes for contributions of cash or property to or for the use of the United States or any State or local government, and certain organizations organized and operated exclusively for "charitable, scientific, literary, educational," etc., purposes (sec. 170). In general, the deduction generally equals the fair market value of the transferred property on the date of the contribution. Where the transfer is an interest that is less than the entire interest in property (e.g., a remainder interest), present law requires that the transfer take certain specified forms in order to be deductible.

In the case of both an individual or a corporation, the maximum amount of charitable deduction allowable for any one year is subject to limitations generally based on (a) the donor's adjusted gross income (in the case of individuals) or taxable income (in the case of corporations), (b) the nature of the property donated, and (c) the type of donee organization.

Percentage limitations.--In the case of contributions to public charities of cash or ordinary income property by

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[9] See Treas. Reg. sec. 1.501(c)(3)-1(e)(1); Rev. Rul. 64-182, 1964-1 C.B. (Part 1) 186.

individuals, the maximum allowable charitable deduction cannot exceed 50 percent of the individual's contribution base (i.e., adjusted gross income with modifications). In the case of contributions to public charities of capital gain property by individuals, the maximum allowable charitable deduction cannot exceed 30 percent of the individual's contribution base. Not-for-profit hospitals specifically qualify as public charities under present law (sec. 170(b)(1)(A)(iii).

In the case of contributions by a corporation, the maximum charitable deduction which may be claimed for any one year is limited to 10 percent of the corporation's taxable income (with certain modifications).

Contributions of ordinary income and unrelated use property.--In the case of contributions of ordinary income property (e.g., inventory) and contributions of tangible personal property the use of which is unrelated to the donee's exempt purpose, the deduction allowed to both individuals and corporations generally is limited to the donor's adjusted basis in the property.

Minimum tax.--For purposes of computing alternative minimum taxable income (AMTI), section 57(a)(6) provides that the deduction for charitable contributions of capital gain property is disallowed to the extent that the fair market value of the property exceeds its adjusted basis. However, a special rule provides that, for taxable years beginning in 1991, section 57(a)(6) does not apply to charitable contributions of tangible personal property.

Carryover of unused charitable contributions.--Contributions in any one year in excess of the percentage limitations may be carried forward and deducted by both individuals and corporations over the following five years (subject to the percentage limitations in those years).

2. Federal transfer taxes

Present law provides for a deduction in computing the amount of any Federal gift tax, estate tax, and generation-skipping tax for amounts transferred to the United States or any State or local government, certain organizations organized and operated exclusively for "charitable, scientific, literary, educational," etc., purposes, and certain organizations of war veterans. Where the transfer is an interest that is less than the entire interest in property (e.g., a remainder interest), present law requires that the transfer take certain specified forms in order to be deductible.

D. Use of Tax-Exempt Bonds by Not-for-Profit Hospitals

In general

Present law generally excludes from income interest on State and local government bonds if the bonds are issued to finance direct activities of these governments (sec. 103). Interest on bonds issued by State and local governments to finance activities of other persons, e.g., private activity bonds, is taxable unless a specific exception is included in the Code. One such exception is for private activity bonds issued to finance activities of charitable organizations described in section 501(c)(3) ("section 501(c)(3) organizations") when the activities do not constitute an unrelated trade or business (sec. 141(e)(1)(G)).

Classification of section 501(c)(3) organization bonds as private activity bonds

Under present law,[10] a bond is a private activity bond if its proceeds are used in a manner violating either (1) a private business test or (2) a private loan test. The private business test is a two-pronged test. First, the test limits private business use of governmental bonds to no more than 10 percent of the bond proceeds.[11] Second, no more than 10 percent of the debt service on the bonds may be derived from private business users of the proceeds. The private loan test limits to the lesser of five percent or $5 million the amount of governmental bond proceeds that may be used to finance loans to persons other than governmental units.

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[10] Before enactment of the Tax Reform Act of 1986, both State and local governments and section 501(c)(3) organizations were defined as "exempt persons," and their bonds generally were subject to the same requirements. As exempt persons, section 501(c)(3) organizations were not treated as "private" persons, and their bonds were not "industrial development bonds" or "private loan bonds" (the predecessor categories to current private activity bonds).

[11] No more than five percent of bond proceeds may be used in a private business use that is unrelated to the governmental purpose of the bond issue. The 10-percent debt service test, described below, likewise is reduced to five percent in the case of such "unrelated and disproportionate" private business use.

Special restrictions on tax-exemption for section 501(c)(3) organization bonds

As stated above, present law treats section 501(c)(3) organizations as private persons; thus, bonds for their use may only be issued as private activity "qualified 501(c)(3) bonds," subject to the restrictions of section 145. The most significant of these restrictions limits the amount of outstanding bonds from which a section 501(c)(3) organization may benefit to $150 million. In applying this $150 million limit, all section 501(c)(3) organizations under common management or control are treated as a single organization. The limit does not apply to bonds for hospital facilities, defined to include only acute care, primarily inpatient, organizations (secs. 145(b) and (c)). A second restriction limits to no more than five percent the amount of the net proceeds of a bond issue that may be used to finance any activities (including all costs of issuing the bonds) other than the exempt purposes of the section 501(c)(3) organization.

Other restrictions

The Code imposes several restrictions on private activity bonds that generally do not apply to bonds used to finance direct State and local government activities. Many of these restrictions also apply to qualified 501(c)(3) bonds.

(1) No more than two percent of the net proceeds of a bond issue may be used to finance the costs of issuing the bonds, and these amounts are not counted in determining whether the bonds satisfy a requirement that at least 95 percent of the net proceeds of each bond issue be used for the exempt activities qualifying the bonds for tax exemption.

(2) The weighted average maturity of a bond issue may not exceed 120 percent of the average economic life of the property financed with the proceeds.

(3) A public hearing must be held and an elected public official must approve the bonds before they are issued (or the bonds must be approved by voter referendum).

(4) If property financed with private activity bonds is converted to a use not qualifying for tax-exempt financing, certain loan interest penalties are imposed (the "change in use" restrictions).

Both governmental and private activity bonds are subject to several other Code restrictions. For example, the amount of arbitrage profits that may be earned on investments of tax-exempt bond proceeds is limited, and most such profits on investments unrelated to the governmental purpose of the

borrowing must be rebated to the Federal Government (sec. 148).

Also, banks and other financial institutions are denied a deduction for an allocable portion of any interest they pay to the extent of their investments in most tax-exempt bonds (sec. 265). The rule does not apply to investments in qualified 501(c)(3) bonds used to finance hospitals where the total amounts of bonds issued by the issuing governmental unit during that year is not more than $10 million.

State and local governments are subject to a volume limitation with respect to the amount of private activity bonds, other than qualified 501(c)(3) bonds, that it can issue (sec. 146).

Finally, interest on private activity bonds, other than qualified 501(c)(3) bonds, is a preference item in calculating the alternative minimum tax for individuals and corporations.

E. Tax Benefits Provided to Not-for-Profit Hospitals by State and Local Governments

State and local governments provide a variety of favorable tax rules to charitable hospitals. For example, all 50 States and the District of Columbia exempt not-for-profit hospitals from property tax, as well as State and local income tax.[12] In addition, State and local governments often grant not-for-profit hospitals exemptions from sales and use taxes.

In some States and localities, the exemption from property tax is dependent upon the hospital being exempt from Federal income tax. In other States and localities, the exemption closely parallels the Federal statute, but does not specifically depend upon the hospital being exempt from Federal income tax.

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[12] David A. Hyman, "The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals," American Journal of Law and Medicine, vol. 16, no. 3, 1991, p. 330.

II. DESCRIPTION OF PROPOSED LEGISLATION

A. Description of H.R. 1374 (Mr. Donnelly)

Explanation of Provisions

Nonqualified hospitals not exempt from tax

H.R. 1374 would provide that an organization would not be exempt from Federal income tax if a substantial part of its activities consists of operating a "nonqualified hospital". In order to avoid classification as a "nonqualified hospital," a hospital would have to satisfy the following three basic requirements designed to ensure that the hospital provides (1) adequate emergency medical services, (2) service to Medicaid patients, and (3) charity care or other community benefits.

Emergency medical care

Under the bill, a tax-exempt hospital generally would be required to operate a full-time emergency room providing emergency medical services to all members of the public requiring emergency services regardless of their ability to pay for such services. The bill would make exceptions to this general rule if (1) a State agency made an independent determination that operating an emergency room by the hospital would be unnecessary or duplicative, or (2) the hospital is a specialty hospital which does not operate an emergency room (such as a long-term or rehabilitation hospital) and which is not a prospective payment hospital under Medicare [13] (referred to as "PPS-excluded hospitals").[14]

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[13] The Federal Medicare program--which provides health insurance to the elderly and disabled--generally reimburses hospitals on the basis of a prospective payment system (PPS). PPS hospitals generally receive a fixed payment per Medicare case. However, some specialty hospitals are excluded from PPS and are reimbursed on a cost-based system.

[14] If a hospital's Medicare provider agreement were terminated or suspended (or if more than one civil monetary penalty were assessed) for failure to comply with emergency medical care requirements under Medicare (referred to as the "COBRA anti-dumping rules"), then the hospital would be treated as not operating an emergency room for each taxable year during any portion of which the termination or suspension was in effect (or the penalties were assessed).

The bill would require the Secretary of Health and Human
(Footnote continued)

Medicaid provider agreement

The bill would require tax-exempt hospitals to have a Medicaid provider agreement[15] with the State in which the hospital is located. This requirement would not be satisfied, however, if the hospital consistently engaged in the systematic practice of refusing to furnish covered services to individuals eligible for assistance under the Medicaid program.[16]

Qualified expenditures for community benefits

The bill would require that tax-exempt hospitals meet at least one of the following criteria: (1) the hospital is a sole community hospital, as defined for Medicare purposes (generally meaning a hospital located more than 35 road miles from any other hospital); (2) the hospital is receiving additional payments under the Medicare or Medicaid programs because it treats a disproportionate share of low-income individuals; (3) the hospital's disproportionate patient percentage as defined for purposes of Medicare[17] is within one standard deviation of the mean of such percentages of all hospitals in the geographic area used for the Medicare wage adjustment[18] (excluding certain specialty hospitals); (4) the

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[14](continued)
Services annually (beginning in 1993) to submit a report to the Secretary of the Treasury listing each hospital which has had its Medicare provider agreement terminated (or a civil monetary penalty assessed) during the previous year for failure to comply with the COBRA anti-dumping rules.

[15] The Medicaid program provides health insurance to certain low-income individuals and is funded partly by the Federal Government and partly by the States. Eligibility for Medicaid varies across States. Hospitals must have a provider agreement with the State in order to receive reimbursements for care of Medicaid patients.

[16] Similar to the emergency medical care rule (see note 14, supra), if there is a termination or suspension of the Medicaid provider agreement (or more than one civil monetary penalty assessed), then the hospital would be treated as not having a Medicaid provider agreement for each taxable year during any portion of which the termination or suspension was in effect (or the penalties were assessed).

[17] The disproportionate patient percentage is the sum of two fractions: (1) the proportion of total Medicare inpatient days attributable to Medicare beneficiaries who receive Supplemental Security Income (SSI) benefits, and (2) the proportion of total inpatient days attributable to Medicaid beneficiaries (42 U.S.C. sec. 1395ww(d)(5)(F)(vi)).

hospital devotes at least five percent of its gross revenues to the provision of charity care;[19] or (5) the hospital devotes at least 10 percent of its gross revenues to "qualified services and benefits," meaning services offered by a community health center providing primary health care in a medically underserved area or by a clinic specializing in substance addiction treatment in such an area, or other services or benefits prescribed in Department of Treasury regulations.

Loss of income tax exemption

Failure to meet emergency care or Medicaid provider agreement requirements.--Under the bill, a hospital which is a nonqualified hospital because it did not satisfy the emergency care requirement or the Medicaid provider agreement requirement would not be exempt from Federal income tax for at least two years after the hospital first becomes a nonqualified hospital. Such a hospital could apply to the Secretary of the Treasury to be exempt from tax after the later of (1) two years after the hospital first becomes a nonqualified hospital, or (2) the earliest date on which the hospital again meets the emergency care and Medicaid provider agreement requirements.

Failure to make qualified expenditures for community benefits.--A hospital which is a nonqualified hospital because it did not satisfy at least one of the criteria of making qualified expenditures for community benefits could elect an alternative penalty in lieu of loss of its tax-exempt status.[20] A penalty would apply in the case of

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[18] Such geographic areas generally correspond to Standard Metropolitan Statistical Areas (SMSAs).

[19] For this purpose, "charity care" would not include bad debt or contractual allowances as defined in regulations of the Department of Health and Human Services. However, contributions which a hospital provides (either voluntarily or pursuant to State or local law) to a charity care pool would be considered devoted to the provision of charity care, regardless of whether the hospital is reimbursed from such pool for charity care which the hospital itself provides.

[20] The bill is unclear as to the period during which a hospital would not be eligible for tax-exempt status due to its failure to make qualified expenditures for community benefits. Also, it appears that even if a hospital elected to have the alternative penalty apply to it in lieu of the loss of its tax-exempt status, the hospital still would be treated under the bill as a nonqualified hospital not

(Footnote continued)

the first taxable year during which a hospital is a nonqualified hospital and would be equal to 10 percent of the amount by which 10 percent of the hospital's gross revenues for the taxable year exceeds the hospital's costs of charity care actually provided during that year. A 100-percent rate would apply for each subsequent year.

Other tax consequences

Loss of eligibility to receive deductible charitable contributions.--If a hospital were a nonqualified hospital under the bill, then it would be treated as not eligible to receive charitable contributions deductible for Federal income, estate, or gift tax purposes.

Loss of tax-exempt financing.--Because a nonqualified hospital would lose its tax-exempt status under section 501(a), it would not be eligible to utilize tax-exempt financing (secs. 145(a) and 150(a)(4)). The bill provides, however, that treatment as a nonqualified hospital would not affect the exclusion from income of interest on any tax-exempt bond issued before the first date the hospital is treated as a nonqualified hospital.

Loss of eligibility for section 403(b) treatment.--Employees of a nonqualified hospital would lose eligibility to defer taxability of compensation under section 403(b).

Reports to State and local governments

The Secretary of the Treasury would be required to notify the State and local governments in which a hospital is located if the hospital either becomes or ceases to be a nonqualified hospital for Federal tax purposes.

Reporting requirements

The bill would impose several new reporting requirements on organizations that operate a hospital and that are required under present law to file an annual information return (Form 990).[21] The following new information would have to be reported on an annual basis: (1) a description of

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[20](continued)
eligible to receive deductible charitable contributions or to utilize tax-exempt bonds.

[21] Thus, churches (and certain related organizations) would not be subject to the new reporting requirements under the bill because they are not required under present law to file annual information returns (sec. 6033(a)(2)).

the nature and costs of uncompensated care provided by the hospital; (2) a description of activities of the hospital which benefit the general community (other than general hospital services); (3) whether the hospital received a Medicare or Medicaid disproportionate share adjustment; (4) the geographic area of the hospital for purposes of Medicare wage index adjustments; (5) the hospital's disproportionate patient percentage (except for certain specialty hospitals); (6) the hospital's Medicaid inpatient utilization rate; and (7) whether the hospital is a specialty hospital for Medicare purposes.

Effective Dates

The provisions of H.R. 1374 generally would be effective on the date of enactment. However, in the case of a hospital that, on the date of enactment, is a nonqualified hospital, the bill's provisions would take effect on the earlier of January 1, 1993, or the first date on which the hospital is no longer a nonqualified hospital.

The new reporting requirements imposed on organizations which operate a hospital would apply to taxable years beginning after December 31, 1991.

B. Description of H.R. 790 (Mr. Roybal)

Explanation of Provisions

Requirements for tax-exempt status for hospitals

H.R. 790 would provide that an organization which operates a not-for-profit hospital would not be exempt from Federal income tax unless the hospital (1) has an open-door policy toward Medicare and Medicaid patients and serves in a nondiscriminatory manner a reasonable number of such patients, and (2) provides in a nondiscriminatory manner sufficient qualified charity care and sufficient qualified community benefits.

Service to Medicare and Medicaid patients

Under the bill, the determination of whether the number of Medicare and Medicaid patients served is a reasonable number would be based on whether the proportion of the hospital's patients which are Medicare patients, and the proportion which are Medicaid patients, are reasonable under the facts and circumstances.

Charity care and community benefits

Sufficient qualified charity care.--H.R. 790 defines "sufficient qualified charity care" to mean that the hospital

incurs unreimbursed qualified charity care costs which are 50 percent or more of the value of the hospital's tax-exempt status for the taxable year.

Qualified charity care costs would include: (1) costs in providing health care without charge (or at a discount based on ability to pay) to persons with no or a limited ability to pay; (2) costs in providing health care for which the charge was deducted as a bad debt (excluding debts payable by third parties); (3) the excess of the costs of providing care to Medicaid patients over the reimbursements for such care; (4) if the community has too few charity care patients in need of hospital care, the costs of providing services (either directly or by contract or other arrangement) to improve the health of members of the community who are medically underserved and disadvantaged.

Sufficient qualified community benefits.--The term "sufficient qualified community benefits" is defined by the bill to mean that the hospital incurs unreimbursed qualified community benefit costs which are 35 percent or more of the value of the hospital's tax-exempt status for the taxable year.

Qualified community benefit costs would include: (1) unreimbursed costs in providing community benefits not customarily provided by taxable hospitals; and (2) the excess of the hospital's unreimbursed qualified charity care costs over 50 percent of the value of the hospital's exempt status for the taxable year.

Calculation of value of exempt status

Under the bill, the value of a hospital's exempt status for a taxable year would be equal to the hospital's gross receipts for the taxable year multiplied by the "national target percentage," meaning the percentage estimated by the Secretary of the Treasury which, when applied to the estimated average gross receipts of tax-exempt hospitals in the United States, will yield an amount equal to the average Federal, State and local tax revenues which are foregone by reason of their exempt status.[22]

The Secretary of the Treasury would be authorized to

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[22] If, in applying the "national target percentage," fewer than 75 percent of the private tax-exempt hospitals would meet the bill's requirements of providing sufficient qualified charity care or sufficient qualified community benefits, then the Secretary of the Treasury would be required to modify the percentage so that 75 percent of such hospitals would satisfy the bill's requirements.

make case-by-case modifications of the national target percentage for individual hospitals if, by reason of a hospital's financial ability or other factors determined by the Secretary, application of the national target percentage to the hospital is inappropriately high or low.

Excise tax penalty for failure to meet charity care or community benefits requirements

Except in the case of an egregious failure by a hospital to meet the bill's requirements of providing sufficient qualified charity care and sufficient qualified community benefits, H.R. 790 would impose an excise tax penalty on the organization operating the hospital failing these requirements in lieu of revoking the tax-exemption of that organization. The excise tax penalty generally would be equal to 100 percent of the "charity care/community benefit shortfall" (i.e., the amount by which the hospital's charity care and community benefits costs for the taxable year fell short of the required expenditures under the bill).[23]

The excise tax penalty would not be applicable to the first taxable year for which a hospital has a charity care/community benefit shortfall. The bill also grants to the Secretary of the Treasury the authority to increase the excise tax penalty otherwise imposed if unusual circumstances exist, but in no event could the penalty be increased to exceed one percent of the hospital's gross receipts for the year.

Other tax consequences

Eligibility to receive deductible contributions.--H.R. 790 does not specifically address whether a hospital not satisfying the bill's requirements would be eligible to receive charitable contributions deductible for Federal income, estate, or gift tax purposes. Consequently, it is unclear whether a hospital not eligible for tax-exempt status under the bill (or subject to the alternative excise tax penalty) would remain eligible to receive charitable contributions deductible for Federal income, estate, or gift tax purposes.[24]

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[23] The bill provides that the excise tax revenues would be used solely to provide additional Federal matching funds under the Medicaid program to the State in which the hospital is located.

[24] The sections of the Code governing such contributions require that the donee be organized and operated exclusively for charitable (or other similar) purposes and not

(Footnote continued)

Tax-exempt bonds.--An organization which loses its tax-exempt status under H.R. 790 automatically would lose its eligibility to receive tax-exempt bond financing because it would no longer be an organization described in section 501(c) and exempt from tax under section 501(a) (secs. 145(a) and 150(a)(4)).

Reporting requirements

Under the bill, every organization which is exempt from Federal income tax under section 501(a) and which operates a hospital would be required to include in its annual information return (Form 990)[25] the following information with respect to each hospital for each taxable year: (1) number of Medicare and Medicaid patients served and a detailed description as to whether that number is reasonable and whether the care provided was nondiscriminatory; (2) total number of patients served; (3) total number of charity care patients served and a detailed description as to whether the care was nondiscriminatory; (4) unreimbursed qualified charity care costs; (5) unreimbursed qualified community benefits costs; (6) community benefits provided which are not customarily provided by taxable hospitals; (7) certification from the appropriate State official that (a) the hospital has openly served Medicaid patients in a nondiscriminatory manner (or, if the State's Medicaid program limited the hospitals that could obtain Medicaid contracts, the hospital made reasonable efforts to be awarded such a contract), and (b) the hospital is expected to meet the requirements of providing sufficient qualified charity care and sufficient qualified community benefits.[26]

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[24](continued)
disqualified for tax exemption by reason of lobbying or political activities, but not that the donee be exempt from tax under section 501(a) (see secs. 170(c), 2055(a), and 2522(a)). It is unclear whether, for purposes of the sections governing deductibility of contributions, a hospital failing the requirements under H.R. 790 would be deemed to be not operated exclusively for a charitable purpose.

[25] Certain organizations (such as churches) are not required under present law to file annual information returns (see note 4, above). However, H.R. 790 would require all organizations which operate a hospital to file annual information returns.

[26] Similar certification from a State official also would be required under the bill when an organization which plans to operate a hospital provides notice to the Secretary of the Treasury that it is applying for recognition of tax-exempt status, as required by section 508.

Department of Treasury reports

Within one year of enactment, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, would be required to submit to Congress recommendations on rewarding hospitals that clearly and consistently meet the requirements for tax-exempt status under the bill, including recommendations on exemptions from the additional reporting requirements added by the bill.

In addition, within two years of enactment, the Secretary of the Treasury would be required to implement (if feasible) a methodology for measuring the Federal, State, and local tax revenues foregone by reason of a hospital's tax-exempt status. If implemented, the Secretary would be required to submit to Congress recommendations (if any) for modifying the bill's standards as to what constitutes sufficient qualified charity care and sufficient qualified community benefits provided by tax-exempt hospitals.

Effective Dates

The provisions of H.R. 790 generally would be effective for taxable years beginning after December 31, 1993. The additional reporting requirements imposed by the bill would be effective for taxable years beginning after December 31, 1992.

III. DISCUSSION OF ECONOMIC ISSUES

A. Overview

The intent of H.R. 1374 and H.R. 790 generally appears to be to increase the amount of charity medical care provided to lower-income individuals. To achieve this goal, both bills would make modifications in the requirements for exempt status of hospitals which choose to operate as not-for-profit hospitals under section 501(c)(3). The efficacy of achieving this goal will depend upon the efficiency of utilizing the tax system to direct economic behavior in this context.

Tax benefits may or may not be efficient or equitable means to produce desired policy results. H.R. 1374 and H.R. 790 attempt to achieve the desired result indirectly by conditioning the benefit of tax exemption upon the provision of a threshold level of medical services to indigent individuals. A fundamental question is whether the means selected by H.R. 1374 and H.R. 790 will accomplish the intended result, and if so, in a cost-efficient way.

To assess the efficacy of using changes in the Internal Revenue Code to achieve the goal of providing medical care to lower-income individuals, the following three sections provide a general discussion of (1) the value of tax benefits to not-for-profit hospitals; (2) the uses to which the benefits of tax exemption may go and the empirical evidence on such uses by not-for-profit hospitals; and (3) issues specific to H.R. 1374 and H.R. 790.

B. Value of Tax Benefits to Not-for-Profit Hospitals

There are four major tax benefits associated with a not-for-profit hospital's Federal tax-exempt status:

(1) Exemption from Federal income tax;

(2) Ability to accept tax-deductible contributions;

(3) Ability to benefit from tax-exempt debt; and

(4) Exemption from certain State and local taxes.

Federal tax-exempt status does not itself provide exemption from State and local taxes, but many States and localities provide exemptions to not-for-profit hospitals based on Federal tax-exempt status.

Federal income tax exemption

Not-for-profit hospitals generally do not pay Federal income taxes on their net income; however, the value of this

exemption is difficult to quantify. Some argue that the value of this exemption is equal to the corporate tax rate multiplied by the net income of not-for-profit hospitals.[27] However, this may not be the appropriate measure in the long run. Because not-for-profit hospitals do not have shareholders, net income cannot be distributed as dividends[28], and thus must be retained. If a hospital's net income is eventually spent on expenses that would be deductible under an income tax, the future tax liability of the hospital is reduced. In this case, the value of the tax exemption is equal to the tax that would otherwise be payable on the income earned on the retained earnings, rather than the corporate tax rate multiplied by a given year's net income.[29]

Tax-deductible contributions

Tax-deductible contributions to not-for-profit hospitals account for roughly 1/2 to 2 percent of hospital revenues.[30] Donations represent a significantly smaller share of revenues for not-for-profit hospitals than for most other section 501(c)(3) organizations,[31] largely because hospitals receive most of their revenues from fees.

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[27] It is difficult to assess how the net incomes of not-for-profit hospitals compare to the net incomes of for-profit hospitals. Comparisons between financial statements are difficult because not-for-profit hospital accounting differs from both Generally Accepted Accounting Principles and from income tax accounting. For instance, not-for-profit hospitals generally value property, plant, and equipment at replacement cost, and base depreciation on this replacement cost figure. In an inflationary environment, this methodology results in a larger depreciation expense for a not-for-profit hospital than for another organization with similar plant and equipment.

[28] This discussion ignores the issue of potential private inurement, which is discussed below.

[29] However, it is difficult to assess what the tax treatment of not-for-profit hospitals would be if they were not tax-exempt, since present law generally requires that there be a profit-seeking motive for expenses to be deductible as ordinary business expenses.

[30] See Hall, Mark and John Colombo, "The Charitable Status of Not-for-Profit Hospitals: Toward a Donative Theory of Tax Exemption," Washington Law Review, vol. 66, number 2, 1991, note 350, p. 406.

Tax-exempt bonds

Not-for-profit hospitals also receive the benefits of tax-exempt bonds, which substantially reduce their borrowing costs. This ability to pay lower rates on borrowing lowers the cost of capital and may increase the investment in plant or equipment by not-for-profit hospitals. The Joint Committee on Taxation has estimated that the tax expenditure for tax-exempt bonds for hospitals in 1992 will be approximately $2.6 billion.[32] This tax expenditure estimate may overstate the value of the subsidy to hospitals, since some of the benefits of tax-exempt bonds may inure to the bondholders.

Exemption from State and local taxes

In addition to exemption from State and local income taxes, not-for-profit hospitals frequently are exempt from State and local property and sales taxes.[33] The value of these exemptions for the late 1980s was estimated to be approximately $1.2 billion per year for the property tax exemption, and $2.4 billion per year for the sales tax exemption.[34]

The exemption from property and sales taxes lowers the hospitals' costs. Therefore, unlike the income tax exemption, this exemption is valuable even to hospitals without net taxable income.

C. Uses of the Benefits of Tax-Exempt Status

Overview

There has been some concern that not-for-profit hospitals do not use all the benefits created by their tax-exempt status in ways that always benefit society. A useful way to approach this issue is to trace how not-for-profit hospitals use the money saved by not paying taxes and by borrowing at lower (tax-exempt) rates.

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31 In 1980, charitable contributions comprised approximately 25 percent of receipts for all not-for-profit organizations. Burton A. Weisbrod, The Not-for-Profit Economy, (Cambridge: Harvard University Press), 1988.

32 Joint Committee on Taxation, Estimates of Federal Tax Expenditures for Fiscal Years 1992-1996 (JCS-4-91), March 11, 1991.

33 See fcotnote 12, supra.

34 Copeland and Rudney, "Federal Tax Subsidies for Not-For-Profit Hospitals", Tax Notes, March 26, 1990.

Not-for-profit hospitals could use the tax savings in the following ways.

(1) Provide free or subsidized services.--Not-for-profit hospitals could use the money saved from their exemptions to pay for care for patients who are unable to pay, to provide free or reduced-cost clinics, or to provide other community services.

(2) Increase employees' compensation.--There has been some concern that not-for-profit hospitals may use their exemption to increase the compensation of their workers. For instance, hospitals could use the funds saved by being tax-exempt to pay bonuses or to provide other benefits to their staffs.[35] Because not-for-profit hospitals do not have shareholders to monitor hospital management, employees at not-for-profits may more easily capture benefits than employees at for-profit hospitals.

(3) Retain net earnings in order to expand in the future.--Not-for-profit hospitals could save the tax benefits for a number of years in order to finance capital expansion. Not-for-profit hospitals might invest in projects that would not be profitable for for-profit hospitals (for example, rural hospitals or community clinics); on the other hand, not-for-profit hospitals might spend the money to expand in ways that benefit their physicians. For instance, they may provide better laboratories which enhance the physicians' prestige, research, etc.

(4) Lower prices or improve service.--Not-for-profit hospitals could reduce prices for all patients to reflect the fact that the hospitals' profits were untaxed, or could provide better services than for-profit hospitals. In this case, not-for-profit hospitals would subsidize the hospital care of all patients, and patients would tend to prefer not-for-profit to for-profit hospitals.

It is not clear to what extent not-for-profit hospitals use their tax savings to finance free or subsidized care, to provide community services, or to serve communities which might not be served by for-profit hospitals (for example, rural or poor communities), and to what extent the tax savings are used in other ways that benefit society less. Empirical evidence has shown mixed results. This evidence is

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[35] Providing "unreasonable" compensation or using the funds in ways that inure to private individuals may jeopardize the income tax exemption of a hospital. However, because it is difficult to define unreasonable compensation, hospitals may be able to pay employees more than the market wage, or provide significant nonmonetary compensation.

summarized in the following discussion.

Empirical evidence of the effects of not-for-profit hospitals on the provision and cost of medical care

Several studies have attempted to measure the extent to which not-for-profit hospitals utilized the benefits of their tax-exempt status to provide more charity care or provide medical care at lower cost than do for-profit hospitals.

Not-for-profit hospitals and the provision of charity care.--Some studies have concluded that not-for-profit hospitals do not provide proportionately more charity care than do for-profit hospitals nor do they charge lower prices for the medical services provided to the general public. For example, the General Accounting Office (GAO) has attempted to measure the amount of charity care provided by not-for-profit hospitals in comparison to that offered by public and for-profit hospitals in five States.[36] The GAO found that not-for-profit hospitals provided a lower percentage of their States' uncompensated care in comparison to the percentage of the total amount of hospital care they provided.[37] Other studies have produced similar results, although the subject is controversial.

There is some evidence that provision of charity care may differ across types of not-for-profit hospitals. The GAO found that the provision of uncompensated care varied substantially among not-for-profit hospitals. It found urban, not-for-profit, teaching hospitals provided uncompensated care roughly in a greater proportion to total care provided by such hospitals than non-teaching, not-for-profit hospitals provided in comparison to total care provided by non-teaching, not-for-profit hospitals.

The methodology utilized in these studies has been criticized. The studies generally find that proportionately the most charity care is provided by public hospitals. This may overstate the extent to which not-for-profit hospitals appear to provide inadequate amounts of charity care. The studies do not take into account potential differences in the

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[36] U.S. General Accounting Office, Nonprofit Hospitals: Better Standards Needed for Tax Exemption, GAO/HRD-90-84, May 1990.

[37] Regina E. Herzlinger and William S. Krasker, "Who Profits from Nonprofits?," Harvard Business Review, vol. 65, January-February 1987, and Paul Fishman and Randall Mariger, "Do Nonprofit Hospitals Provide More Subsidized Health Care than Do For-Profit Hospitals?," unpublished paper, Department of Economics, University of Washington, May 1991.

quality of medical service provided. If not-for-profit hospitals offer higher quality medical service, the studies cited above would understate the quality-adjusted level of charity care provided. Some have criticized the use of simple measures of uncompensated care to measure charity care. For example, data from the State of Florida indicated that almost 50 percent of patients whose bills were classified as "bad debt" had incomes of less than 150 percent of the poverty line or had suffered catastrophic medical expenses.[38] Consequently, studies, such as that of the GAO, which examine only reported charity care may understate the extent to which charity care is provided. However, it is not clear that any such understatement is greater for not-for-profit than for for-profit hospitals.

Others note that not all charitable or community benefits provided by not-for-profit hospitals are measurable by admittances or medical services provided in the hospital itself. For example, the GAO study found that not-for-profit hospitals were more likely to provide community services (such as health screening and immunizations) than for-profit hospitals, and that these services were more likely to be targeted to low-income people than were services offered by for-profit hospitals. However, while not-for-profit hospitals were more likely to provide community services, not-for-profit hospitals also were more likely to charge fees to recover the costs of providing these services.

Tax exemption and cost of hospital services.--One would expect for-profit hospitals to locate where market conditions would permit the hospital to charge high prices and earn high profits. Consequently, inherent in a comparison of the prices charged by not-for-profit and for-profit hospitals is a bias toward finding higher prices charged by for-profit hospitals.[39] One such study claims to have found that for-profit hospitals charge approximately 20 percent more than not-for-profit hospitals for the provision of similar care.[40] However, other studies suggest that there are no significant price differences between not-for-profit and

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[38] Unpublished data from Center for Health Policy Research, University of Florida Health Center, "State University Study of Indigent Care," 1988, as cited in Lewin/ICF, "The General Accounting Office Report on Hospital Tax Exemption: An Analysis," prepared for The Catholic Hospital Association, July 11, 1990.

[39] Mark V. Pauly, "Nonprofit Firms in Medical Markets," American Economic Review, vol. 77, May 1987. Pauly stresses that cost comparison studies are flawed because the location and production decisions of for-profit firms are endogenous and no empirical study has accounted for this endogeneity.

for-profit hospitals.[41]

D. Analysis of H.R. 1374 and H.R. 790

Charity care measures

Both H.R. 1374 and H.R. 790 include requirements that not-for-profit hospitals provide at least threshold amounts of charity care or community benefit as a condition of being granted tax-exempt status. H.R. 1374 defines charity care as medical services provided free of charge to the recipient. H.R. 790 defines charity care more broadly than does H.R. 1374. The charity care definition used in H.R. 790 encompasses the same measure used in H.R. 1374, and then adds the following items as qualified charity care: (1) costs in providing health care deducted as a bad debt (excluding bad debts from third parties (e.g., insurers)); and (2) the excess costs of providing care to Medicaid patients over the amounts received as reimbursement.

The different definitions of charity care would provide different incentives to hospitals. The exclusion of bad debts from the definition of charity care under H.R. 1374 would require hospitals to determine upon admission whether an uninsured patient is likely to pay the medical bills they will incur during a hospital stay. To classify the medical costs for a patient as charity care, the hospital must choose to forego the possibility of full or partial payment for the medical services rendered.

On the other hand, the broader definition of charity care in H.R. 790 may make it easier for hospitals to circumvent the charity care requirements. For instance, the ability to count the unreimbursed cost of Medicaid care as charity care under H.R. 790 may provide hospitals with an incentive to reclassify certain expenses (e.g., overhead costs) as Medicaid costs, in order to increase the amount of charity care they are credited with performing. This

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40 J. Michael Watt et al., "The Comparative Economic Performance of Investor-Owned Chain and Non-for-Profit Hospitals," New England Journal of Medicine, vol. 314, January 9, 1986.

41 See, Frank A. Sloan and Robert A. Vraciu, "Investor-Owned and Not-for-Profit Hospitals," Health Affairs, vol. 2, Spring 1983, and Herzlinger and Krasker, "Who Profits from Nonprofits?"; and Fishman and Mariger, "Do Nonprofit Hospitals Provide More Subsidized Health Care than Do For-Profit Hospitals?"

reclassification should not result in a substantial change in revenues from Medicaid or from other sources, but will increase the likelihood of meeting the charity care requirement imposed by H.R. 790. Similarly, hospitals could create artificial bad debts by increasing the prices charged for services provided to uninsured patients, but attempt to collect only a portion of the charges. H.R. 790 would count these bad debts as charity care.

The American Institute of Certified Public Accountants, in its 1990 Audit Guide for Providers of Health Care Services, requires hospitals to disclose their charity care policies and the amount of charity care in their financial statements. This requirement may help hospitals comply with the charity care requirements under these bills, since these costs would be accumulated for financial reporting purposes. However, the financial statement requirement may permit more leeway for hospitals to define charity care as they wish, as long as there is full disclosure on the part of the hospital. Presumably, the requirements of these bills would encourage hospitals to standardize the reporting of charity care for both financial statement purposes and tax purposes.

Other requirements of H.R. 1374 and H.R. 790

Although the definition of charity care in H.R. 1374 is narrower than that in H.R. 790, the overall requirements for tax-exempt status are broader in H.R. 1374 than in H.R. 790. H.R. 790 would require virtually all hospitals to perform some amount of charity care and to provide some amount of community services (which may include charity care in excess of the standard). H.R. 1374, on the other hand, would exempt a number of hospitals from charity care requirements. Hospitals that receive additional payments for serving a disproportionately large number of Medicare or Medicaid patients, hospitals whose disproportionate patient percentage (DPP) falls within one standard deviation of the mean DPP in the geographic area (generally the Standard Metropolitan Statistical Area (SMSA)) where the hospital is located, as well as sole community hospitals, would not be required to meet any charity care standards in order to qualify for tax-exempt status under H.R. 1374. Furthermore, hospitals spending 10 percent of gross revenues on community benefits would not have to meet the 5-percent charity care test. These options may allow hospitals more flexibility to meet the patient needs of their communities. However, these options also may allow certain hospitals to meet the requirements without providing an increased amount of charity care. For instance, hospitals in wealthy communities may serve a smaller share of Medicaid patients than hospitals in poorer communities, simply because the average DPP in that community is lower. Thus, hospitals in wealthy areas may find it easier to meet the disproportionate care standard. Similarly, hospitals with disproportionately large shares of

Medicaid patients receive some compensation for the extra burden and may therefore devote less of their resources to charity care than other hospitals with significant, but not disproportionately large, shares of Medicaid patients. Further, it is not clear whether being the sole hospital in a community entails providing significant amounts of community services. Some argue, however, that since a sole community hospital must be at least 35 road miles from any other hospital, such a hospital must provide substantial amounts of community services.

Under H.R. 1374, the amount of charity care is compared to a percentage of gross revenues for the hospital. This is a relatively simple comparison, as long as there is little disagreement on what constitutes gross revenues (e.g., it is unclear whether interest earnings on investments would be included in gross revenues for a hospital). By contrast, under H.R. 790, the amount of charity care is compared to the average value of the tax-exempt status (including the exemption from Federal, State, and local income, property, excise, and sales taxes) for a hospital in the United States. The Secretary of Treasury is charged with computing the average value of tax-exempt status for hospitals as a percentage of gross revenues, with the added constraint that this percentage figure should not disqualify more than 25 percent of the hospitals in the United States from meeting the charity care requirement. This is likely to be a difficult computation under the best of circumstances, since adequate data may not exist. The increased reporting under H.R. 790 will help in these computations, but it should be noted they will be quite inexact for several years. In addition, it is likely that the value of tax exemption for a hospital will vary widely, since a large part of the value of the tax exemption will depend on State and local tax practices. The use of a national average figure may be viewed as unfair by hospitals where the exemption from State and local taxes provides a relatively small subsidy.

Excise tax sanctions

Under H.R. 790, a not-for-profit hospital would be able to retain its tax-exempt status by paying an excise tax equal to 100 percent of the charity care/community benefit shortfall. How substantial the excise tax is will depend on the Treasury Secretary's computation of the value of tax exemption for the average U.S. hospital. H.R. 1374 would permit a not-for-profit hospital to pay a similar excise tax equal to 100 percent of the deficiency between the amount of charity care provided and 10 percent of the hospital's gross revenues as an alternative to the loss of tax exemption. The excise tax rate is reduced to 10 percent for the first year that a hospital does not meet the charity care requirement (that is, the 100-percent rate is applied to hospitals that do not meet the requirement two or more years in a row).

This lower rate for the first year of noncompliance may provide an incentive for hospitals to allocate the amount of charity care to particular years in a strategic manner. For instance, by allocating the bulk of charity care to alternating years, it may be possible for a hospital to provide aggregate charity care substantially below the required level, but be subject to the lower 10-percent excise tax penalty only in alternating years. This possibility could be addressed by allowing the lower excise tax only once for any hospital.

Presumably, those hospitals which find it relatively less costly to meet the charity care requirements under either of the bills would be most likely to change their behavior in order to avoid sanctions. To the extent that State and local governments follow the Federal determination of tax exemption in setting property and sales tax rates, the imposition of sanctions at the Federal level could result in a substantial financial burden, and few hospitals may willingly face the loss of tax-exempt status. It is unclear, however, whether society is well served by requiring all hospitals to meet uniform targets for providing charity care. Certain benefits that may accrue to specialization may be lost when all hospitals are required to meet similar requirements for maintaining their tax exemption.

Potential consequences of the loss of tax exemption

Tax exemption and the market for the provision of medical services.--If the standards for tax exemption are more difficult to achieve, fewer hospitals may be organized as not-for-profit hospitals. This may affect the provision of hospital services by altering the structure or overall size of the hospital market.

There is little empirical evidence on the role of tax-exempt status in determining the size and structure of markets in which not-for-profit hospitals participate. Because the benefits of Federal income tax exemption do not vary by State studies which have attempted to assess the effect of tax exemption on the provision of medical services generally rely upon differences in the tax exemption accorded not-for-profit hospitals across States or local jurisdictions. As such, the results may not be entirely relevant to interpreting potential changes in qualifications for Federal tax exemption. One study which utilized data across States from 1975 estimated that local property tax exemption, sales tax exemption, and State corporate income tax exemption were important factors in explaining the share of medical services provided by not-for-profit hospitals within a given State.[42] On the other hand, a study which examined the effect of variation in property tax exemptions within a single State found no evidence that the exemption altered the share of medical services provided by

not-for-profit hospitals.[43]

In neither case do the results of these studies address the question of whether increasing or decreasing the share of not-for-profit hospitals in the market for medical services has any effect on the total provision or price of medical services.

Section 501(c)(3) status and the deductibility of charitable contributions.--Loss of tax-exempt status also may affect specific hospitals by denying these hospitals the ability to accept tax-deductible charitable donations. Analysts have undertaken numerous studies to determine the extent to which the tax deductibility of charitable donations and bequests increases (or decreases) the amount of funds which flow to recipient organizations.[44] Many of the studies have suggested that deductibility of charitable contributions by individuals is efficient in that at least as much money flows to charitable organizations as would have been collected in tax revenue in the absence of the deduction. There is some limited evidence that deductibility of charitable contributions may induce proportionately more funds to flow to hospitals than to all charitable organizations as a whole.[45]

Critics have noted that these studies rely on cross section data which may be inappropriate for accurately measuring taxpayer behavioral response to proposed tax law changes.[46] Moreover, all these studies attempt to assess the

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[42] Henry Hansmann, "The Effect of Tax Exemption and Other Factors on the Market Share of Nonprofit Versus For-Profit Firms," National Tax Journal, vol. 40, March 1987.

[43] Cyril F. Chang and Howard P. Tuckman, "Do Higher Property Tax Rates Increase the Market Share of Nonprofit Hospitals?," National Tax Journal, vol. 43, June 1990.

[44] For example, see Charles T. Clotfelter, Federal Tax Policy and Charitable Giving, (Chicago: University of Chicago Press), 1985. Clotfelter provides a detailed survey of the literature.

[45] Martin S. Feldstein, "The Income Tax and Charitable Contributions: Part II--The Impact on Religious, Education, and Other Organizations," National Tax Journal, vol. 28, June 1975.

[46] For example, see Joseph Daniel, "Price and Income Elasticities of Charitable Contributions: New Evidence from a Panel of Taxpayers," unpublished paper, University of

(Footnote continued)

effect of tax deductibility on aggregate charitable giving, rather than giving to any specific organization. The results of such studies may not be relevant to the loss of tax exemption by any given hospital. However, as noted above, charitable contributions on average constitute a small fraction of the total revenue of not-for-profit hospitals.

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[46](continued)
Minnesota, 1989. Daniel uses a panel of taxpayers and finds that less money flows to charitable organizations than would flow to the Federal government if the deductibility of charitable contributions were repealed.